Connecticut Department of Social Services

Making a Difference

Testimony Before the Human Services Committee

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S. B. No. 989 (RAISED) AN ACT CONCERNING THE ALZHEIMER'S RESPITE CARE PROGRAM.

S. B. No. 1060 (RAISED) AN ACT ESTABLISHING AN ACCOUNT FOR THE BENEFIT OF SUPPORTED LIVING IN GROUPS HOMES

Claudette Beaulieu
Deputy Commissioner for Programs
March 3, 2009

Good morning Senator Doyle, Representative Walker and members of the Human Services Committee. My name is Claudette Beaulieu and I am the deputy commissioner for programs of the Department of Social Services. I am pleased to be here this morning to present testimony on two bills introduced at the request of Governor Rell implementing features of the Governor's biennial budget recommendation to the Connecticut General Assembly. I am also happy to have this opportunity to testify on the merits of child support enforcement legislation raised by the committee at the request of Commissioner Starkowski. My testimony includes written remarks on several other bills on the agenda.

As we indicated in our testimony before the Appropriations Committee in support of Governor Rell's budget recommendation for the Department of Social Services, these are extraordinary times of economic adversity. We are seeing economic problems that are well beyond the scope of recent downturns:

- residents across the state are trying make ends meet with reduced wages or hours of work
- others have lost their jobs
- businesses are scaling back, or in some cases closing
- home foreclosures are up
- people fortunate enough to have been able to save for retirement or other needs have seen the value of those nest eggs drop dramatically
- the price of food, fuel, and clothing and just about everything else has gone in the opposite direction---only getting higher
- people are curtailing spending and looking to find ways to do more with less.

And virtually everywhere we look, we see the same across the country. The national economic outlook will take some time to improve, even with the efforts being made in Washington by the President and Congress to intervene and reverse the economic decline.

All these forces are coming to bear on state budgets, and Connecticut is no exception.

- As Connecticut workers lose jobs or have their hours reduced, demand for services of the Department of Social Services has risen
    - As just one example, applications for the Supplemental Nutrition Assistance Program (formerly known as Food Stamps) were up 30% in the October to December 2008 quarter, compared to the same time in 2007.
- We are facing a projected budget deficit in SFY 2009 of over $922 million.

- Over the biennium, this shortfall is estimated by the Office of Policy and Management to increase to over $6 billion.

- Other states are facing problems of even larger magnitudes, and may not have the benefit of having "rainy day funds" to help offset the deficit.

Understanding that DSS expenditures of over $5 billion equate to 28.1% of the overall SFY 2010 budget, the Department must be a significant part of any effort to balance the budget.

Just as Connecticut families are scaling back and tightening their budgets, so must we.

The Governor's recommended budget for DSS, while it does contain reductions, allows us to maintain our core functions and services to those most in need. Unlike what is happening in some other states, the Governor's recommended budget protects that which is most important and in some critical areas even expands benefits. Significantly, the Governor's recommended budget provides for expected caseload increases in vital programs as more Connecticut residents apply for services. And the Governor's budget also protects recent eligibility-level expansions in HUSKY for parents, relative caregivers and pregnant women.

The combined total of the Governor's recommended changes in the DSS appropriation result in current service reductions of $382 million in SFY 2010 and $438 million in SFY 2011, for a total reduction over the biennium of $820 million.

Governor Rell stated in her budget address that none of the proposed cuts were easy to make and that they are not inconsequential, but that they do represent a return to a level of government spending that is affordable in these times. The Governor's proposed budget, which incorporates the federal economic stimulus package, allows us to hold our core services in place until the economy recovers.

I'd like now to turn to a discussion of the details of the Governor's bills before the committee.

S. B. No. 843 AN ACT IMPLEMENTING THE GOVERNOR'S BUDGET RECOMMENDATIONS CONCERNING SOCIAL SERVICES.

I will be remarking on the sections of the bill pertaining to DSS.

Sections 1 and 8 – Provide non-citizens with emergency health care services only

Under federal rules, non-citizens who have been in the country for more than five years are eligible for Medicaid and their costs are federally reimbursable. States have the option of providing coverage to non-citizens who have been in the country for less than five years, but the costs are 100% state funded. Connecticut is one of only fourteen states providing coverage for non-citizens through state-only funds. The Governor recommends that the state-funded Medicaid be eliminated and that DSS only provide non-citizens with emergency health care services, which are federally reimbursed. This change is expected to save $23.6 million in FY 2010 and $24.5 million in FY 2011.

Sections 4 – 7, 9 – 12 - Community and Social Services Block Grant and Employment Services Block Grant

The Governor's budget calls for the creation of a Community and Social Services Block Grant and an Employment Services Block Grant. Under these provisions, funding from certain non-entitlement programs within DSS are reallocated into block grants and distributed according to a plan developed by regional planning councils, subject to review and approval by DSS, OPM and legislative committees of cognizance. This is consistent with the theme of regionalism in the Governor's budget. The combined savings from these initiatives is expected to be $3 million in both FY 2010 and FY 2011.

Sections 13, 15, 17, 65, 66, 68 - Medicare Part D and ConnPACE Changes

Some adjustments to programs are proposed where necessary to reflect either new programs or funding available at the federal level. The maturation of the Medicare Part D pharmacy benefit has allowed Connecticut to rethink the necessity of the state's Medicare Part D Supplemental Needs Fund, as prescription drug plans are required to cover those drugs that are medically necessary. In line with the benefits provided by other states, Connecticut will no longer provide coverage of non-formulary drugs under Medicare Part D, as prescription drug plans are required to cover all medically necessary drugs.

Both dually eligible clients (those who are eligible for both Medicare and Medicaid), and ConnPACE clients will be required to enroll in one of the 12 basic benchmark plans under Medicare Part D. It has been found that the current enhanced plans do not provide any additional benefits over the lower costing basic plans. With no lock-in, dually eligible clients have the ability to switch plans on a regular basis as their drug regimens change. Other states do not do this. For ConnPACE clients, pharmacists will provide that upfront assistance to make sure the client is enrolled in the most appropriate plan that meets their needs.

Like the vast majority of states, Connecticut will no longer cover all of the Medicare Part D co-pays charged to dually eligible (Medicare and Medicaid) clients under the federal prescription drug assistance program, resulting in savings of $3.7 million in FY 2010 and $4.0 million in FY 2011. To ensure that these co-pay provisions are not overly burdensome, clients will not be responsible for pharmacy co-pays of more than $20 per month.

The Governor's budget also calls for a number of modifications to ConnPACE and the other pharmacy programs. Given the significant expenditures made by DSS each year for pharmaceuticals ($564.3 million on FY 2009), program revisions are proposed which would save $86.0 million in FY 2010 and $94.5 million in FY 2011. A large portion of these savings are related to the elimination of non-formulary coverage for Part D enrollees ($26.2 million in FY 2010 and $28.7 million in FY 2011) and the restructuring of the ConnPACE program ($25.0 million in FY 2010 and $27.5 million in FY 2011). Savings initiatives include adding mental health related drugs to the preferred drug list, requiring prior authorization on certain high cost drugs, reducing pharmacy

reimbursement levels, eliminating coverage of most over-the-counter drugs to the extent allowed under federal law, and adding co-pay requirements (up to $20 per month).

Changes under the ConnPACE program include increasing the annual enrollment fee from $30 to $45, freezing income eligibility levels over the biennium, and instituting an open enrollment period similar to commercial plans and the Medicare Part D program. In addition, by adopting the same asset test used to determine eligibility for the federal low-income subsidy under Medicare Part D, ConnPACE benefits will be targeted to those most in need.

Currently, persons dually eligible for Medicare and Medicaid, and ConnPACE recipients in Medicare Part D may enroll in any Part D prescription drug plan of their choice. CMS pays the monthly benchmark premium ($31.74 in calendar year 2009) for those individuals receiving the federal Part D low-income subsidy, but when clients enroll in a plan costing more than the benchmark amount, DSS pays the difference. Of the 47 prescription drug plans available to enrollees in program year 2009, 26 are enhanced plans, with premiums ranging as high as $111.30. Clients are increasingly enrolling in enhanced plans, although generally there are no substantive benefits to the higher costing plans.

The Governor recommends requiring all dually eligible and ConnPACE recipients participating in Medicare Part D to enroll in one of the 12 benchmark plans. Limiting enrollment to benchmark plans will simplify the coordination of benefits and premium payment and plan reconciliation. This proposal is expected to save $900,000 in FY 2010 and $1.8 million in FY 2011.

Section 14 – Study SAGA waiver

This provision requires DSS to study the impact of implementing a waiver to extend Medicaid coverage to individuals with income up to 100% of the federal poverty level who would otherwise qualify for medical assistance under SAGA. By moving forward with a study, the cost-effectiveness of this approach can first be determined prior to resources being devoted to the development and submission of a full blown waiver proposal.

Sections 16, 22, 50-53 - Nursing Home, ICF-MR and Residential Care Home Rate

The budget includes a proposal to eliminate the rebasing of nursing home rates that would have resulted in a 9.64% increase in FY 2010 and a 3% inflationary adjustment in FY 2011 resulting in savings of $115.3 million in FY 2010 and $166.4 million in FY 2011.

We are proposing to move one-half of the June 2010 payment for nursing homes to July 2010, with this delay continuing in subsequent years. This would result in a one-time savings of $53.1 million in FY 2010.

The proposed budget eliminates the rate add for Intermediate Care Facilities for the Mentally Retarded. Elimination of the 4.7% and 4.9% increases in FY 2010 and FY 2011, respectively, for ICFs for those with developmental disabilities would result in savings of $2.9 million in FY 2010 and $6.2 million in FY 2011.

In addition, to control future costs, the budget proposes a cap on the total number of beds under 'small house nursing home" projects. Further development is restricted by capping the number of beds at 280 through the biennium.

Section 18 – Over-the-Counter Drugs

The Governor recommends eliminating coverage of over-the-counter drugs, with the exception of insulin and insulin syringes, under the department's pharmacy programs. This change is consistent with the current policy under the ConnPACE program. To comply with federal rules, Connecticut will continue to provide coverage of over-the-counter drugs to all children under the age of 21 under the HUSKY A program. This change is expected to save $7 million in FY 2010 and $7.7 million in FY 2011.

Sections 19 – 20, 48 Copayments, Premiums and Self Declaration

Given the high cost of health care, cost sharing is proposed as an alternative to restricting eligibility under a number of DSS programs. Many states – up to 44 – already have some form of cost-sharing in their Medicaid programs. Co-payments and premiums are introduced under Medicaid (to include HUSKY A), and client financial participation is increased under the HUSKY B program as an alternative to reducing or eliminating eligibility. Cost sharing will be required under Medicaid not to exceed 5% of family income on allowable medical services (excluding hospital inpatient, emergency room, home health, laboratory and transportation services), resulting in savings of $8.5 million in FY 2010 and $10.5 million in FY 2011.

Consistent with federal rules, children under age 21, individuals at or below 100% of the federal poverty level, SSI recipients, pregnant women, women being treated for breast or cervical cancer and persons in institutional settings are exempt from the cost-sharing requirement.

The Governor is also proposing to establish monthly premiums for HUSKY-eligible adults, not to exceed federal maximum levels, for savings of $8.8 million in FY 2010 and $9.3 million in FY 2011. Premium amounts will be determined on a sliding scale.

Finally, under HUSKY B, individuals with income between 236% and 300% of the federal poverty level will be required to pay higher premium amounts, which will result in savings of $1.5 million in FY 2010 and $1.6 million in FY 2011. Through these cost sharing measures, critical health care programs can be maintained and eligibility restrictions avoided.

In addition to the establishment of premiums for HUSKY A adults and modifications to premium payment requirements under HUSKY B, the budget eliminates self-declaration of income under HUSKY A, resulting in estimated savings of $2 million in both FY 2010 and FY 2011 through a tightening of eligibility screening.

Section 21 - Hospital Never Events

This legislation is not expected to be needed as this authority was included in the recent deficit mitigation legislation, HB 6602, which has been transmitted to the Governor for signature.

The Governor's budget includes implementation of provisions to deny Medicaid payment to hospitals for 'never events.' These are serious and costly errors in the provision of health care services that should never happen. This proposal mirrors the Medicare policy on non-payment for these types of errors. The savings estimated as a result of this initiative is $1.7 million in FY 2010 and $1.8 million in FY 2011.

Sections 23 – 39 - False Claims

The federal Deficit Reduction Act of 2005 authorizes the state to bring a civil action against any individual or entity who engages in fraud against the state of Connecticut. This proposal includes 'qui tam' provisions allowing individuals to initiate claims and allowing the Attorney General to substitute the state of Connecticut for such individual's civil action. The federal government will provide financial incentives to states that adopt this qui tam law for purposes of recovering Medicaid funds in such actions.

Section 40 - Interpreter Services

In the 2007 session, the legislature provided funds to implement a statewide medical interpreting service under the Medicaid program, effective April 1, 2008.
The Governor recommends that DSS not amend the Medicaid state plan to include foreign language interpreter services as a covered service under the Medicaid fee-for-service program with the expectation that providers will continue to provide interpreter services for individuals with limited English proficiency, for a savings of $5.5 million in FY 2010 and $6 million in FY 2011.

Sections 41 -42 - Payments Standard Freeze

Under current law, effective July 1, 2009 and July 1, 2010, recipients of Temporary Family Assistance, State Administered General Assistance, and the Aid to the Aged, Blind and Disabled programs are scheduled to receive a state-funded cost of living adjustment based on the percentage increase in the Consumer Price Index - Urban (CPI-U), assumed to be 6.0% in FY 2010 and 3.5% in FY 2011. These increases total $7.7 million in FY 2010 and $11.8 million in FY 2011.

Additionally, under current statute, DSS is required to annually determine rates for various boarding homes. Per DSS regulations, boarding home rate increases are based on actual cost reports submitted by facilities, barring any legislation to remove rate increases for a particular fiscal year. These increases total $4.5 million in FY 2010 and $9.3 million in FY 2011.

The Governor recommends eliminating these statutory increases.

Section 43 - Child Support Disregard

The Governor's budget also proposes an increase in the amount of child support recoveries paid to families. This proposal increases from $50 to $100 the amount of the current child support payment that is disregarded and passed through to families receiving Temporary Family Assistance. Increasing the disregard provides families with additional financial support and a greater incentive to cooperate in securing child support for their children. Since October 2008, the Deficit Reduction Act no longer requires states to reimburse the federal government for 50% of child support payments collected and disregarded. As a result of this change in federal law, the child support pass-through can be increased to $100 at no cost to the state.

Sections 44 – 45 - Dental limitations

Other program reductions or eliminations are necessary to deal with the fiscal crisis. Adult dental benefits under the Medicaid and SAGA programs will provide emergency services only, coverage similar to that offered by most other states. According to the National Academy of State Health Policy (October 2008), only 16 states (including Connecticut, MA, NY, NJ) currently provide comprehensive adult dental services. Most states provide only emergency or partial adult dental services; 6 do not provide any adult dental services at all.

Section 47 - Pharmacy Reimbursement

The Governor recommends reducing the dispensing fee paid to pharmacy providers for each prescription filled under the department's pharmacy programs from $3.15 to $2.15. This change will save $4.1 million in FY 2010 and $4.5 million in FY 2011. In addition, The Governor recommends reducing the reimbursement level to pharmacy providers from the average wholesale price (AWP) minus 14% to AWP minus 15%. This change is expected to save $6.5 million in FY 2010 and $7.1 million in FY 2011.

Section 54 - Maintain Home care caseload levels

The Governor proposes capping the caseload under the state-funded Connecticut Home Care Program for Elders at June 30, 2009 levels, for a savings of $4.8 million in FY 2010 and $14.5 million in FY 2011. As clients move off the program, new clients can begin to receive services under the state-funded program. The program will re-open without restrictions beginning in July 2011.

Sections 55 – 58 – Money Follows the Person

For the chronic care waiver population, DSS planned to transition one individual in FY2009, 14 individuals in FY 2010 and 24 individuals in FY 2011 at an average annual cost of $148,260 per year. DSS is projected to spend $2.7 million in year one transition costs for 24 clients in FY 2011. Although this represents just under 12% of the approximately 200 transitions anticipated in FY2011, it accounts for over 26% of the costs. To address the extremely costly nature of these clients, the operational protocol will be revised to limit the number of transitions under the chronic care waiver to no more than 2% of the 700 clients expected to be transitioned under the demonstration period. By the end of the next biennium, after the bulk of the transitions have occurred under the demonstration period, DSS will reassess this policy to determine where the state's limited resources should best be targeted.

Section 59 - Small House Nursing Home Pilot Cap

PA 08-91 requires DSS to establish, within available appropriations, a pilot program to support the development of up to ten "small house nursing home" projects with the goal of improving the quality of life for nursing home residents by providing care in a more home-like setting. While each unit can house no more than ten individuals, each project can have multiple units. One project that is in the early stages of development will convert approximately 280 certified beds to this model. To control future costs, any further development of "small house nursing home" projects over the biennium is restricted by capping the number of beds at 280 through the biennium. This proposal saves $1.5 million in FY 2011.

Section 60 - Medically Necessary Definition

Savings of $4.5 million in FY 2010 and $9 million in FY 2011 are estimated under a proposal to replace the current medical necessity definition under Medicaid with the definition for SAGA medical. This medical necessity definition was recommended by the University of Connecticut Health Center Physician Advisory Team under the leadership of Dr. Peter Deckers. The definition would combine the concepts of medical necessity and appropriateness under a single definition as is done in Medicare and under most public sector and commercial health care programs, and it would update the department's definition to provide for evidenced-based medical necessity decisions.

Section 61 – State Supplement Trust

When recipients of the State Supplement Program (AABD) receive Social Security (SSA) benefits in combination with another source of income, such as a pension, their income may, over time, reach levels which makes them ineligible for further AABD assistance. When this occurs, they are likely to move into a higher cost nursing home setting. The Governor proposes allowing special needs trusts to be used to reduce the countable income of those boarding home residents whose increased income would have

made them ineligible for AABD. This change will enable them to remain in a boarding home and avoid nursing home placement. It is anticipated that this change will affect approximately 25 residents each year, and result in a savings to the state of $918,153 in FY10 and $1.2 million in FY11.

Section 62 – Medication Administration Revisions

The Governor recommends requiring that residential care homes and boarding homes have individual employees certified so that they can provide medication administration to their residents. Nurses will still be required to administer all injections. This proposal provides additional funds for training, liability insurance, supervision and other implementation costs and results in a net savings under the Medicaid program. This proposal has a net savings of $1.5 million in FY10 and $2.9 million in FY11.

Section 63 - Increase Capias Mittimus Officers

The governor proposes legislation to increase the number of capias mittimus sworn police officers allowed under statute from four to six. This proposal is expected to result in a revenue gain of $85,000 due to increased child support collections that offset state public assistance costs. From January 1, 2003 through December 31, 2008, a backlog of almost 5,000 unserved capias mittimus orders in family child support matters has accumulated.

In conclusion, the fiscal crisis presents clear challenges, but Governor Rell's proposed budget responds to those challenges by ensuring that critical health and human services are preserved while also respecting the fiscal limitations confronting the state. The reductions proposed in the budget are tempered by significant investments in serving additional Connecticut residents through the most critical health care and social service programs, and by new initiatives designed to help those affected by the economic downturn.

The level of resources provided in the budget for all of the health and human services agencies demonstrates an extraordinary commitment to maintaining services for those in need, despite the challenges facing Connecticut's economy.

H. B. NO. 6379 AN ACT IMPLEMENTING THE GOVERNOR'S BUDGET RECOMMENDATIONS CONCERNING MAXIMIZATION OF PHARMACY REBATES.

Introduced at the request of Governor Rell, this legislation will require pharmaceutical manufacturers participating in DSS pharmacy assistance programs to provide rebates for covered prescription drugs.

The bill fast tracks the implementation of additional rebates by relieving DSS of administratively burdensome drug rebate contracting requirements by eliminating the need to enter into individual contracts for each program with each pharmaceutical labeler. It may be of interest to the committee to know that there are thousands of

labelers and without this legislation DSS would have to contract individually with each manufacturer for each program, to achieve the scope of rebates that were anticipated when DSS moved forward with the pharmacy carve-out and that have been assumed in the Governor's budget. Indeed, upon adoption, DSS will have clear authority to move forward with invoicing and collecting rebates on all drugs covered under all of our programs.

For the committee's information, please note the following circumstances under which DSS currently collects rebates. We collect rebates on all drugs we cover under the Medicaid program (which includes HUSKY A) where a federal rebate agreement is in place. DSS also receives supplemental rebates for these programs as well, based on the Department's Preferred Drug List. We also collect regular rebate from manufacturers who participate and have a signed rebate agreement under our ConnPACE program. CADAP has a limited formulary and for those drugs, we do collect rebate.

For SAGA we are currently collecting minimal rebate for drugs covered under that program. Prior to the SAGA program going into managed care, we required the manufacturers to have a separate rebate agreement with us in order to cover their drugs (similar to ConnPACE). Once SAGA was included under managed care, some of those manufacturers terminated those contracts and some did not (we, the state, did not terminate any agreements). Now that SAGA is back in-house, we are working with the manufacturers to either re-initiate their old contracts or ask that they sign a new contract. This is taking some time. We currently do not collect supplemental rebate for the SAGA program at this time, but we intend to do so. For Charter Oak and HUSKY B, we are collecting neither regular rebate nor supplemental rebate as pharmaceutical manufacturers are requesting individual contracts to do so. For Medicare Part D non-formulary drugs that we pay for, we are only collecting rebate for those drugs under the ConnPACE program, not under Medicaid for the dual eligibles.

This legislation would clearly outline for the pharmaceutical manufacturers exactly what their responsibility would be in order for their drugs to be covered and paid for by DSS and we urge your support.

Legislation Introduced at Request of the Department

H. B. No. 6543 (Raised) An Act Concerning Paternity And Support Establishment And Enforcement Of Orders In Title Iv-D Child Support Cases

This bill would improve ESTABLISHMENT & MODIFICATION of support orders in the following ways.

FIRST, the bill would exempt the child support agency from proving "neglect or refusal to support" as a pre-condition for a support order in a Title IV-D case. The existing language occasionally has made order establishment problematic in cases in which a child support order is required due to the custodial party's participation in the child support program, but the noncustodial parent cannot be shown specifically to have

"refused or neglected" to support. An order in accordance with the child support guidelines offers a measure of security for the family while ensuring the obligor's ability to pay is fully considered.

SECOND, the bill would establish a procedure for notifying the parties associated with a disapproved Agreement to Support, or "ATS" and docketing that agreement for a hearing on support. Under present law, there is no procedure for when a Family Support Magistrate disapproves an ATS. Therefore a support petition is usually necessary, which causes unnecessary delay in the support establishment process. The bill provides that the reason for disapproving an ATS will be stated in the record, and the clerk will schedule a hearing to determine appropriate support amounts and notify all parties of the hearing date.

The bill also amends the FAMILY SUPPORT MAGISTRATE'S ACT.

The bill builds on the existing authority of family support magistrates to order obligors to pursue work activities when they owe past-due support by permitting child support orders individually tailored to improve a parent's ability to meet the legal obligation to support. This provision would allow family support magistrates to enter a variety of orders related to things like work programs, and educational and skill-building programs designed to increase an obligor's capacity to satisfy current or past-due support obligations.

Next, the bill would improve ENFORCEMENT in child support cases in two ways.

FIRST, it would grant specific authority for judicial marshals to execute child support capias mittimus orders in court facilities when the subject of the order is in the custody of the judicial marshal or within a courthouse where the judicial marshal provides security. This provision will increase the timely and expeditious service of such orders for the purpose of resolving child support matters and supporting judicial authority.

SECOND, the bill would increase the cap on the number of special police officers employed by the Department of Social Services, Bureau of Child Support Enforcement from four to eight. The increase in the cap will permit the hiring of additional officers as funds may become available.

Finally, the bill would improve INCOME WITHHOLDING for child support.

The bill would authorize *electronic* service of income withholding orders, and clarify the term "issue" when applied to such orders. The provision allows service of income withholding by electronic means when the employer subject to the withholding order has agreed to accept withholdings electronically. It also clarifies the term "issue" in the context of electronic income withholding to mean transmission of the essential data by electronic means. Electronic service of income withholding will save state costs for mailing and printing the orders.

Thank you for this opportunity to testify in support of Bill # 6543, and I now invite any questions you may have.

Additional Legislation Affecting the Department

H. B. No. 6524 (Raised) An Act Concerning Managed Care For Certain Medicaid Beneficiaries.

The Department opposes this bill, which calls for the enrollment of the Aged, Blind and Disabled (ABD) population of the Medicaid program into a managed care environment. While there are benefits to managed care, this would be a major program change requiring substantial policy review (for example, the implications for two-thirds of enrollees who are dually eligible for Medicaid and Medicare); contractual resources (complex because most care for dually-eligible enrollees is paid by Medicare); and administrative resources, which are stretched thin by current programs and initiatives.

More generally, the impression that the ABD population receives only minimal care utilization management is inaccurate. The Medical and Clinical Review Team does provide care utilization management. Much of the team's efforts centers on care coordination of many of our most complex and needy clients. Each member of the team follows a list of special needs clients for whom they coordinate care, facilitate referrals, arrange services, coordinate services with other state agencies, and other services as requested. These efforts are targeted to access necessary services. Additionally, depending on the progress and success of the Primary Care Case Management initiative for HUSKY members, it's possible that such model could have value for our ABD health coverage members.

The Department does not support the change called for by H.B. No. 6524 at this time.

H. B. No. 6610 (Raised) An Act Concerning Medicaid Income Limits For Aged, Blind And Disabled Persons.

This bill would increase the Medicaid program's income limit for aged, blind and disabled persons by increasing the limit for these individuals to the level used in the HUSKY program for families that include parents and caretaker relatives. The effect of this change would be to more than double the income limit for the existing program from an effective limit of approximately $788, for most elderly, blind and disabled participants, to $1670 per month, which is 185% of the federal poverty level for one person. Such an increase in the income limit would permit thousands of additional individuals to qualify at an increased cost of many millions of dollars to the state. Given the current circumstance of the state's budget, this would not be a prudent action and the department must therefore oppose this bill.

H. B. No. 6544 (Raised) An Act Simplifying Procedures For Early Care And Early Education Facilities.

The department does not believe that legislation is necessary to address the intent of the bill. We are currently working with the proponents of this bill to address the reporting requirements for child care facilities. In light of that, we are opposed to this legislation.

H. B. No. 6526 (Raised) An Act Concerning Activities Of The Council That Monitors The Temporary Family Assistance Program And Employment Services Program.

This bill would require the Departments of Social Services and Labor to submit an ongoing quarterly report to the TANF Council and the Human Services Committee concerning a large range of detailed information about recipients of Temporary Family Assistance and Jobs First Employment Services.

The Department of Social Services has always been willing to provide the types of information required by this bill when it has been requested by the General Assembly and in particular the TANF Council. We have complied with all such requests in as timely a manner as possible. However to impose such an extensive a reporting requirement on a quarterly basis when agency resources are already burdened with other responsibilities is unreasonable. Compiling this voluminous data would require additional resources to accomplish. We therefore must strongly oppose this bill.

S. B. No. 989 (Raised) An Act Concerning The Alzheimer's Respite Care Program.

This bill seeks to increase the benefit levels of this program, add the service of Personal Care Assistant and increase the income and asset levels for participants. The department is not able to support the increased income and asset limits. The department would be in favor of greater flexibility to allow the few clients who demonstrate a need for increased services to receive them based on a regulated criteria. Not all clients would be eligible for the maximum benefit of $7,500.

Since the initial legislation creating the program in 1998, clients who participate in the Connecticut Statewide Respite Care Program have been eligible to receive up to $3,500 in respite services per year to help them to continue to reside at home. In SFY'08, 813 clients (an increase in 157 from SFY'07) received services such as adult day care, companion/homemaker and home health aide. Given that there are over 100,000 individuals in Connecticut with diagnoses of dementia who may be eligible at some time for this program, many more can be expected to seek the program's assistance in coming years. While this has represented a very meaningful respite benefit for caregivers, the cap in services per client has not kept pace with the increasing cost of community-based services and may be quickly exhausted by families in need. Care Managers for this program utilize a multifaceted screening tool to ascertain the client's level of need for services, and money is allocated in varying increments in order to serve the greatest number of clients.

In order to increase the number of service options available to care recipients under the Connecticut Statewide Respite Care Program, the Department supports the inclusion of "personal care assistants" as a service under this program. This will allow recipients to use individual providers of their choice and possibly reduce the cost of their care or allow for a greater number of hours of service since the client or their family will be able to negotiate a rate under a provided maximum level.

The department opposes the increase in income and asset limits for this program for the following reasons:

Currently, the income and asset limits for eligibility under this program are $30,000 and $80,000 respectively for the individual with Alzheimer's disease. The current income guideline for the Medicaid portion of the Connecticut Home Care Program for Elders, the program offering the most similar type of services, is $22,428, and higher for the state-funded portion based upon applied income and a sliding scale. Currently, the average client receiving services under the Connecticut Statewide Respite Care Program has an annual income of around $20,000. If access to the state funded portion of the Connecticut Home Care Program for Elders is frozen as of SFY'10, it will likely result in an increase in applications for the Connecticut Statewide Respite Care Program. In order to be able to most equitably serve the neediest clients, the Department proposes maintaining the current income and asset levels for SFY'10 and SFY'11 and does not support this bill's proposal to increase them and build in a permanent Social Security

S. B. No. 1060 (Raised) An Act Establishing An Account For The Benefit Of Supported Living In Groups Homes.

This bill establishes a special account for support to individuals in group homes. Currently, individuals in licensed group homes and supported living setting receive financial assistance and assistance with medical and daily living/personal services through programs administered by DSS, DDS and DMHAS. These programs are administered in accordance on policies and procedures developed based applicable statutes and/or regulations. We oppose establishing a separate account to provide additional or new services that will require additional administration when existing programs are available and may be modified through state legislative and budgeting process.

At this time, I would appreciate the opportunity to respond to any questions you may have. Thank you.